DESERT VISIONS YOUTH WELLNESS CENTER
P.O. Box 458
Sacaton, Arizona 85247
Tel: 888-431-4096

APPLICATION

For

ADMISSION

MISSION STATEMENT

Desert Visions Youth Wellness Center provides
Native American people culturally relevant behavioral health
Treatment to intervene in addictive lifestyles, to assist
In the development of dignity and self-respect while
Instilling hope and promoting wellness in adolescents,
Families and communities.

VISION STATEMENT

Desert Visions Youth Wellness Center is the path
To wellness for Native American youth who are in
Need of behavioral health care.

DESERTVISIONS
YOUTH WELLNESS CENTER

Long ago, our people say, there was a beginning.

It began with a Man. He was at the beginning. This man began his life journey through a Maze. This Maze, our elders say, represents our path through life. It is what a man travels through in his walk of life. Our people say a man's journey has many lessons. Lessons of learning. Lessons of knowledge. A man can make these lessons positive or negative. As the man travels through this Maze, he has many choices. Sometimes the man walks into a wall and he may have to take another path, but always inside the Maze. At the center of the Maze, the man finds the End of his journey. Some elders say it could be the end of the man's journey on earth and he is reborn to a new life – a spiritual beginning, another path. Others say that this center represents the man's spiritual awareness and he begins his life anew.

No matter, there are many paths that one must walk in the Maze of life.

To the young person who enters Desert Visions treatment is a Maze. It can be a positive or negative experience for you. Treatment will become whatever you choose it to be.

We hope that you will choose to make your Desert Visions treatment a positive experience.

Welcome.

The Man in the Maze story above is adapted from the Hia-Ced, Ake Dem and Tohono O'Odham tribes.

APPLICATION PACKET CHECKLIST

To ensure timely processing of application:

Name **Chart No.**

Provide Copies of:

- * **Social Security Card**
- * **Birth Certificate**
- * **Tribal Enrollment**
- * **Guardianship papers (if applicable)**
- * **Court Order to Treatment (if applicable)**
- * **Insurance Card**
- * **AHCCCS Card**

Use current version of application materials.
Send originals of application materials in one packet.
Complete all items. All signatures MUST BE in place and legible.

Page(s)	Description	Concerns, Issues, Possible Problems
_____	1 Application Packet Checklist	* **Legal Guardian:**_____
_____	2 Admission/Readmission Criteria	
_____	3-10 Client Identifying Information	* Completed and signed by interviewer at referring agency.
_____	11 Young Men -- What to Bring	
_____	12 Young Women -- What to Bring	
_____	13 Consent for Medical Treatment	* Items 11 & 12, on Page 10, Diagnosis meeting DSM-IV criteria. Lower. levels of treatment exhausted. Diagnosis that client meets DSM-IV or ICD-10
_____	14 Consent for Client Treatment	
_____	15 Consent to Photograph and Film Client	
_____	16 Consent for Client to Participate in Outings and Wilderness Experiences	
_____	17 Client Agreement	*FROM: Hu Hu Kam Hospital TO: Desert Visions
_____	18 Consent to Photograph and Film Client's Artwork	
_____	19 Authorization to furnish information and	* Two Polaroid pictures are taken of client upon admission for medical chart.
_____	Assignment of Benefits	
_____	20 Consent for Haircuts	* *Desert Visions may pay for two haircuts during treatment.*
_____	21 Approved List of Client Contacts	
_____	22 Consent for Release of Information	* FROM: Desert Visions TO: Mental Health
_____	23 Consent for Release of Information	* FROM: Mental Health TO: Desert Visions
_____	24 Consent for Release of Information	* FROM: Client's School TO: Desert Visions
_____	25 Consent for Release of Information	* FROM: Desert Visions TO: Client's School
_____	26 Consent for Release of Information	* FROM: Desert Visions TO: Aftercare Counselor
_____	27 Consent for Release of Information	* FROM: Aftercare Counselor TO: Desert Visions
_____	28 Consent for Release of Information	* FROM: Desert Visions TO: Probation Officer
_____	29 Consent for Release of Information	* FROM: Probation Officer TO: Desert Visions
_____	30 Consent for Release of Information	*FROM: Hu Hu Kam Hospital TO: Desert Visions
_____	31 Consent for Release of Information	*FROM: Desert Visions TO: Parent/Legal Guardian

APPLICATION PACKET CHECKLIST (cont.)

32-33 **History & Physical Exam -- Acceptable Format**

Be sure clinic and doctor names are LEGIBLE. Must be done within 30 days of intake. Contain statement saying client is stable for treatment at DV. (Must be done by Doctor PA, or nurse practitioner).
Must arrive with the packet. Packet cannot be submitted to Treatment Team for action without H & PE

_____ Medical Alert_____ Special Needs _____ Allergies

34 **Immunizations Record**

____ Immunizations Current, Verification by Desert Visions Nurse

____ PPD (TB Skin Test), Date Read _____

Immunizations must be current. PPD (TB skin test) given and results read with past year with legible dates/signatures.

Desert Visions Youth Wellness Center

Admission Criteria/Readmission Criteria

Criteria for Admission/Re-Admission to Desert Visions Youth Wellness Center shall include:

1. Age range between 12 and 18.

2. Must be an enrolled member of a federally recognized tribe, or provide proof of direct Tribal lineage or affiliation.

3. The client meets DSM IV or ICD-10 criteria for substance abuse disorder in accordance with standardized and widely accepted criteria as diagnosed by a credentialed or licensed provider.

   A. There must be a primary diagnosis meeting DSM-IV or ICD-10 criteria for substance abuse or dependence.
   B. There may be a secondary Axis I or Axis II diagnosis. (Axis III diagnoses must be specified, including "No diagnosis".)

4. Completion of a health and physical examination, done within **30 days prior to admission.**

Clients with the following conditions are NOT appropriate for Desert Visions:

1. Medical instability (any person who is experiencing an acute medical problem that would preclude benefiting from Desert Visions treatment).

2. Actively suicidal or having a history of suicide attempts or gestures.

3. History of violent behaviors sufficient to be a threat to staff or clients.

4. Acute psychosis (any person experiencing episodes of hallucinations, significant delusions or significant thought disorder).

5. Intellectually challenged (any person having an I.Q. of 70 or less or having other equivalent cognitive deficiencies which would prohibit benefiting from treatment).

PLEASE PRINT - USE BLACK INK

Desert Visions Youth Wellness Center

Client Identifying Information

Date:_____

Client's Name: _____ Date of Birth_____ M I F I Age:_____

S.S.#: _____ Place of Birth: _____

Tribal Affiliation: _____ Degree of Indian Blood: _____ Religion: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

PARENTS:

Mother's Name:_____ Deceased?_____

Tribal Affiliation:_____

Address: (if different than above) _____ Phone: _____

City:_____State:_____ Zip:_____

Father's Name:_____Deceased?_____

Tribal Affiliation: _____

Address: (if different than above) _____ Phone: _____

City:_____ State:_____Zip:_____

Is the client Court Ordered to Treatment? Yes __ No __

What are the consequences of not completing treatment?_____

What are the consequences of AWOL (running?)_____

EMERGENCY CONTACT:

Name:_____Relationship to Client:_____

Home Phone: _____ Work Phone: _____

LEGAL GUARDIAN:

Name:_____Relationship to Client:_____

Tribal Affiliation:_____

Address:_____

City:_____ State:_____Zip:_____

Phone:_____

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PATIENT IDENTIFICATION	NAME *(First, M.I., Last)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

AFTERCARE COUNSELOR:

Name and Title:_____

Name of Program:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #: ( )_____ Pager #: ( )_____

PROBATION OFFICER:

Name and Title:_____

Name of Program:_____

Address:_____

City;_____ State:_____ Zip:_____

Phone #: ( )_____ Pager #: ( )_____

A. EDUCATIONAL HISTORY:

I. Grade school: _____

2. High school: (Please circle) 1 yr. 2 yrs. 3 yrs. 4 yr. GED

3. Is client still in school? Yes i No i

4. Has client been in special education classes? Yes [No I

5. Has client been sent home from school because of drinking or dug use? Yes i No i

6. Has client ever been expelled from school? Yes I No I

Why was client expelled? _____

_____

Is client in danger of being expelled now? Yes I No I

Why? _____

7. Is client having any other school problems? Yes I No I

If yes, please explain: _____

_____

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B. FAMILY/RELATIONSHIP HISTORY:

I. Are client's biological parents still living together? Yes I No I

2. If parents are separated or divorced, with whom Does Client live? Mother I Father I other I

If you checked "other", please list. Name(s): _____

Relationship: _____

3. Is client adopted? Yes I No I

4. Does client have children? Yes I No I

If so, how many? _____ Ages _____

C. LEGAL HISTORY:

I. Does Client have any charges pending? Yes I No I

If so, what are they? _____

2. Has Client had previous arrests? Yes I No I

If so what were the charges? _____

3. Being referred to Desert Visions by:

I Aftercare Counselor I Probation Officer I Tribal Court I Behavioral Health

I County Court I School I Family Doctor I Attorney I Parent

4. Does Client have a Pending Court Hearing? Yes I No I

If yes, when is your court date? _____

5. Has Client been in treatment before for alcohol or drugs? Yes I No I

If yes, where? _____

6. Is the client under Child Protective Agency care? Yes I No I

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D. MEDICAL PROBLEMS AND PHYSICAL CHALLENGES:

1. Is the client allergic to medications, foods, insect stings, plants? YES [NO h If YES, what is client allergic

to? _____

2. Asthma? YES I NO I
3. Diabetes? YES I NO I
4. Seizure Disorder? YES I NO I
5, Tuberculosis? YES I NO I
6. Heart Problems? YES I NO I
7. Hepatitis? YES I NO I
8. Other medical problems _____

_____

9. What medications have been prescribed for the client? _____
10. Is the client pregnant? YES I NO I

    If Yes, how many weeks pregnant? _____

    Who is providing prenatal care for the client?_____
11. Is the client physically challenged? (for example, does the client use a wheelchair, crutches, cane or does the client have vision or hearing difficulties?) _____

E. EMOTIONAL/BEHAVIORAL:

1. Does the client have a history of an eating disorder? (obesity or restrict food intake to keep weight dangerously low, or binge eat and then vomit or exercise to maintain weight?) YES I NO I

   If YES, describe: _____
2. Does the client have a history of fire setting? YES I NO I

   If Yes, describe: _____
3. Does the client of a history of cruelty to animals? YES I NO I Describe: _____

   _____
4. History of bedwetting? YES I NO I
5. Has the client been hospitalized for emotional/mental problems? YES I NO I

Hospital	Location	Dates of treatment	Reason for Admission

6. Has the client seen a psychiatrist, psychologist, counselor or traditional healer for emotional/mental

problems? YES I NO I

7. Does the client have a history of self-injury or suicide attempts? YES I NO I

Date: Method Name of Hospital # Days in Hospital Substance Abuse Involved?

_____

_____

_____

Additional information, re: suicide attempts, such as intervention/treatment: _____

_____

8. Is the client currently self-harmful or suicidal? YES I NO I

If YES, describe: _____

9. Does the client have a history of violence: YES I NO I If YES, describe: _____

_____

a. History of violence to self or others? (e.g. self-choking, etc.) YES I NO I
b. Has client been a victim of violence from others? YES I NO I
Describe: _____

10. Has the client been involved in a gang? YES I NO I If YES, which gang? _____

Gang colors: _____

Describe the client's involvement with the gang: _____

_____

<u>Has Client used any of the following?</u> **(Please check)**

- o **Sedative Hypnotics/ tranquilizers** (Valium, Librium, Miltown, Phenobarbital, etc.)
- I **Psychotropics** (Stelazine, Cogentin, Thorazine etc.)
- I **Tranquilizers** (Valium, Librium Miltown, etc.)
- I **Barbiturates** (Quaaludes. Phenobarbital, Nembutal, Tuinal, Seconal)
- I **Stimulants-amphetamines** (Dexedrine, Crystal, Benzedrine, Methedrine, etc.)

- o **Sleeping pills**

o **Opiates** (heroine, morphine, opium, etc.)

o **Pain killers** (Darvon, Darvocet, codeine, etc.)

o **Hallucinogens** (LSD, STP, MDA, PCP, mescaline, etc.)

o **Cocaine**
If so, how often? _____

f **Cannabis** (Marijuana)
If so, how often?_____

l **Steroids:** _____

o **Tobacco:** Smoking g How much? _____ Chewing o How much? _____

l **Caffeine:** (Coffee, Soda) f How much per day? _____

l **Inhalants** (Glue sniffing)
If so, how often? _____

l **Other**
Type: _____

Has the client had withdrawal or severe hangovers in the past? YES l NO l

If YES, which substances caused withdrawal or severe hangovers _____

_____

Blackouts?

_____

_____

Has the client had residential treatment for Substance Abuse? YES l NO l

Residential Facility Dates of treatment If NOT successfully completed, WHY?

_____

_____

Has the client had outpatient treatment for Substance Abuse? YES l NO l

Outpatient Program Counselor Dates of treatment 12-Step Experience included?

_____

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Other Issues the Client may need help with:

1.	Speech disorder (e.g., lisp, stutter)	YES I	NO I
2.	Learning problems in school	YES I	NO I
3.	Grades	YES I	NO I
4.	Truancy	YES I	NO I
5.	Suspended or expelled from school	YES I	NO I
6.	Delinquent (arrested or referred to juvenile court)	YES I	NO I
7.	Run away	YES I	NO I
8.	Juvenile Detention	YES I	NO I
9.	Depression	YES I	NO I
10.	Stealing	YES I	NO I
11.	Possession of weapons	YES I	NO I

F. TREATMENT ACCEPTANCE/RESISTANCE

Is the client willing to come to treatment voluntarily? YES I NO I

G. RECOVERY ENVIRONMENT

1. Who currently lives in the home with the client? (list names, ages and relationship to client)

   _____

   _____

   _____

2. Is there anyone currently living in the client's home who is in poor health? YES I NO [
   If YES, describe condition: _____

3. Is there anyone currently living in the client's home who is an active substance abuser? YES I NO I
   If YES, relationship and substance abused: _____

4. Is there anyone currently living in the client's home who is active in a program of recovery? YES [NO[
   If YES, relationship and circumstances: _____

5. Does the client have access to an Aftercare Program? YES [NO [
   If yes, what organization? _____

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6. What are the current plans for the client after treatment?

Living Situation: _____

_____

School Work: _____

_____

Aftercare Program: _____

_____

7. What is the family expectation of the client? _____
8. Family strengths: _____

_____

9. Family Liabilities:_____

10. Additional Information: _____

_____

_____

_____

11. Diagnoses: (Include Substance Abuse and Mental Health problems)

_____

_____

_____

_____

12. Explain why Outpatient Treatment is not sufficient at this time: _____

_____

_____

_____

_____

_____ _____

Print Name of Client Interviewer/Title Date

_____ _____

Signature of Client Interviewer/ Title Date

Phone: _____

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PATIENT IDENTIFICATION	NAME *(First, M.I., Last)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my record.
(Name of Patient)

II. The information is to be disclosed by: P.O./PAROLE	**And is to be provided to:** DVYWC
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS	ADDRESS PO Box 458
CITY/STATE	CITY/STATE Sacaton, AZ 85247

III. The purpose or need for this disclosure is:

_____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Entire Record
- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify)* _____
- ☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☒ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event*. _____
*(Enter if different from **one year after** date below)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

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PATIENT IDENTIFICATION

NAME *(Last, FIrst, MI)*	RECORD NUMBER
ADDRESS	
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Instructions for Completing IHS Form 810 -- AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.

2. Section I, print name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Entire Record** -- the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)

   b. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** -- specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.

   d. **Other *(specify)*** -- e.g., CHS, billing, employee health

   e. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX!**

6. Section V, sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

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Indian Health Service

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Expiration Date: 05/31/2006
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IHS-810 (4/03)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my record.
(Name of Patient)

II. The information is to be disclosed by: DVYWC	**And is to be provided to:** CLIENT'S SCHOOL
NAME OF FACILITY Desert Visions Youth Wellness Center	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS PO Box 458	ADDRESS PO Box 458
CITY/STATE Sacaton, AZ 85247	CITY/STATE Sacaton, AZ 85247

III. The purpose or need for this disclosure is:

_____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Entire Record
- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify)* _____
- ☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☒ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event*. _____
*(Enter if different from **one year after** date below)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, FIrst, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

Instructions for Completing IHS Form 810 -- AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.

2. Section I, print name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Entire Record** -- the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)

   b. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** -- specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.

   d. **Other *(specify)*** -- e.g., CHS, billing, employee health

   e. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

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      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX!**

6. Section V, sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
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NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS	ADDRESS PO Box 458
CITY/STATE	CITY/STATE Sacaton, AZ 85247

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8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

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Indian Health Service

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(Name of Patient)

II. The information is to be disclosed by: DVYWC	**And is to be provided to:** Hu Hu Kam Hospital
NAME OF FACILITY Desert Visions Youth Wellness Center	NAME OF PERSON/ORGANIZATION/FACILITY Hu Hu Kam Hospital
ADDRESS PO Box 458	ADDRESS ATTN: Medical Records PO Box 38
CITY/STATE Sacaton, AZ 85247	CITY/STATE Sacaton, AZ 85247

III. The purpose or need for this disclosure is:

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IV. The information to be disclosed from my health record: *(check appropriate box(es))*

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8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my record.
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II. The information is to be disclosed by: HU HU KAM	**And is to be provided to:** DVYWC
NAME OF FACILITY Hu Hu Kam Hospital	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS ATTN: Medical Records PO Box 38	ADDRESS PO Box 458
CITY/STATE Sacaton, AZ 85247	CITY/STATE Sacaton, AZ 85247

III. The purpose or need for this disclosure is:

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PATIENT IDENTIFICATION

NAME *(Last, FIrst, MI)*	RECORD NUMBER
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7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

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NAME OF FACILITY Desert Visions Youth Wellness Center	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
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IHS-810 (4/03)
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3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Entire Record** -- the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)

   b. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** -- specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.

   d. **Other *(specify)*** -- e.g., CHS, billing, employee health

   e. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX!**

6. Section V, sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my record.
(Name of Patient)

II. The information is to be disclosed by: P.O./PAROLE	**And is to be provided to:** Parent/Legal Guardian
NAME OF FACILITY Desert Visions Youth Wellness Center	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS PO Box 458	ADDRESS PO Box 458
CITY/STATE Sacaton, AZ 85247	CITY/STATE Sacaton, AZ 85247

III. The purpose or need for this disclosure is:

_____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Entire Record
- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify)* _____
- ☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☒ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event*. _____
*(Enter if different from **one year after** date below)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, FIrst, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

Instructions for Completing IHS Form 810 -- AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.

2. Section I, print name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Entire Record** -- the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)

   b. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** -- specify date range, e.g., Jan 1, 2002 to Feb 1, 2002.

   d. **Other *(specify)*** -- e.g., CHS, billing, employee health

   e. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX!**

6. Section V, sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my record.
(Name of Patient)

II. The information is to be disclosed by: DVYWC	**And is to be provided to:** Probation or Parole Officer
NAME OF FACILITY Desert Visions Youth Wellness Center	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS PO Box 458	ADDRESS PO Box 458
CITY/STATE Sacaton, AZ 85247	CITY/STATE Sacaton, AZ 85247

III. The purpose or need for this disclosure is:

_____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Entire Record
- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify)* _____
- ☐ **Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☒ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date *or expiration event*. _____
*(Enter if different from **one year after** date below)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, FIrst, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

Instructions for Completing IHS Form 810 -- AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.

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   a. **Entire Record** -- the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)

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   d. **Other *(specify)*** -- e.g., CHS, billing, employee health

   e. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

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   f. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX!**

6. Section V, sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Form IHS-810 will be given to the patient.

IHS-810 (4/03)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 05/31/2006
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my record.
(Name of Patient)

II. The information is to be disclosed by: DVYWC	**And is to be provided to:** AFTER CARE COUNSELOR
NAME OF FACILITY Desert Visions Youth Wellness Center	NAME OF PERSON/ORGANIZATION/FACILITY Desert Visions Youth Wellness Center
ADDRESS PO Box 458	ADDRESS PO Box 458
CITY/STATE Sacaton, AZ 85247	CITY/STATE Sacaton, AZ 85247

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8. A copy of the completed Form IHS-810 will be given to the patient.